GOVERNMENT OF KARNATAKA

Sudha SR-7 S-TOR RB-6

PRIMARY HEALTH CARE SYSTEM DEVELOPMENT

DIRECTORATE OF HEALTH AND FAMILY WELFARE SERVICES
HEALTH AND PLANNING
FEBRUARY 1990

COMMUNITY HEALTH CELL

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GOVERNMENT OF KARNATAKA

POPULATION & HEALTH PROFILE

The eighth biggest State in the country, Karnataka is having at present an estimated population of about 44 millions (1989) distributed among 4 Revenue Divisions, 20 Districts, 175 Taluks and 250 Towns & Cities.

The rural population of the State is 72% (1981) General Literacy rate is 38.5% (1981). The population below poverty line is 35% (1983-84). The State reveals a birth rate of 29.0 , a death rate of 8.7 and an infant mortality of 74 as on 1986.

There are a total number of 1860 Government Health and Medical Institutions having a total bed strength of 28,822.

The Government health institution population ratio works out to about 1 : 20000 in rural areas and about 1:38000 in urban areas.

The Doctor population ratio works out to about 1:10000 excluding teaching college staff and about 1:8000 including teaching college staff.

The Health and Family Welfare Department has a total man power of 53,225 working under 69 categories.

During the 7th Five Year Plan, the State has allocated Rs.128.00 crores to Health and Family Welfare Department out of Rs.4275.00 crores under State Plan Budget which works out around 3.00% of the total State Plan budget.

The per-capita expenditure on ' Health ' works out to Rs.69.00 (1988-89 BE).

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(3) SANITATION:

Sanitation is a connotation not limited to latrines, embracing personal hygiene, community well being, garbage management, low cost housing, water supply drainage system, refuse collection and environmental health in general.

At the end of 6th Five Year Plan, only 0.72% of the rural population had access to sanitation facility. Sanitation facilities in rural areas are either non - existent or inadequate. Even 2% of the village population is not having the facilities of sanitary latrines, whereas 53% of the population has no access to any kind of sanitation not even the pit latrine.

As per the 1981 census, about 264 lakh people reside in 52623 habitation in the State. Considerable headway has been made in providing safe drinking water to the rural folk. But nothing has been done in providing sanitary latrines. Not only this is a big challenge physically but financially also the outlays involved are enormous. The physical and financial targets even for 25% coverage of our rural population will be Rs.2000lakhs.

In view of the financial constraints, the funds allocated in rural sanitation upto the 7th Five Year Plan is very insufficient and achievement could not cross even 2% coverage. However, the rural sanitation programme has been taken up under State Sector(30 lakhs) RLEGP-109 lakhs, NREP and CRSP .

Recently, the Sulabh International on the basis of experiences and field trials has developed 11 types of Sulabh Shouchalays which are suited for rural areas. The cost (1984) ranging from Rs.200 to Rs.2000 to suit to the different socio and economic groups generally found in the villages.

The Karnataka Land Army Corporation is also involved in the construction of latrines in the villages.

(4) MATERNAL & CHILD HEALTH CARE:

During 1988-89, the details of achievement under M.C.H. Care is as follows:-

Percentage of ante-natal registration(Urban& Rural)	:	88.54
Deliveries conducted by Female Health Workers (Urban & rural)	:	42.9%

Total Births(1988-89)	:	634230
Neonatal deaths	:	34 per thousand per live birth.
Infant deaths	:	15.7 -do-
Maternal deaths:	:	0.6 -do-

(5) FAMILY PLANNING:

Keeping in view of the objectives and goals under Family Welfare Programme i.e. the NNR of 1, CBR of 21, CDR of 9, IMR less than 60 and CPR of 60 by 2000 A.D. Action is being taken to improve the quality of services and also the targets fixed both in family welfare and immunisation programmes.

The targets achieved during 1988-89 under various methods are as follows:

Sterilisation	:	92.7%
IUD	:	97.5%
CC Users	:	101.7%
OP Users	:	116.3%

(6) IMMUNISATION AGAINST INFECTIOUS DISEASES:

The Universal Immunisation Programme was implemented in the State during 1985-86. Since then, batch of districts are being covered in a phased manner and at the end of 1989-90, all the 20 districts will be covered by this programme. Further, under Immunisation mission of technology mission, lot of importance is being given to quality of services than mere chasing the numbers.

The progress under vaccines during 1988-89 are as follows:

DPT	:	98.1%
Polio	:	96.8%
BCG	:	110.6%
Measles	:	83.7%
DT	:	76.6%
TT(mothers)	:	87.1%
TT(10 yrs)	:	78.8%
TT(16 yrs)	:	63.8%

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(7) PROVISION AND SUPPLY OF ESSENTIAL DRUGS:

The essential drugs as listed by W.H.O and Government of India have been kept in mind and atleast one of the members from each group has been carefully selected and are being supplied for different institutions depending upon the capabilitiyes and specialities of the health man-power and also needs. The broad group of drugs include the following:

(1) Anaesthetics
(2) Analgesics
(3) Anti-Pyretics
(4) Anti-allergic, antidotes and other substances used in poisoning.
(5) Anti-epileptics
(6) Anti-infective drugs(Anthaleminthics, anti-bacterial, antifunfal, antiprotozoal).
(7) Anti-migraine.
(8) Haematinics
(9) Gastro-intestinal
(10) Eye & ear drops
(11) Anti-hypertensives
(12) Cortico steriods.
(13) Vitamins.
(14) Skin applicants
(15) Dressings and other materials.

(C) INVOLVING SECTORS OTHER THAN HEALTH:

- The social welfare sector is involved alongwith health sector in implementation of ICDS component. The Anganwadi workers are actively involved in supplementary nutrition, non formal education to pre-school children and also helping in immunisation, health check-up, referral services and health & nutrition education.

- The education sector is involved in educating and motivating the rural people on health, family welfare and immunisation programme. Teachers are also given training in population education, so that in turn the teachers would educate the students in population problem.

- The Public Health Engineering Department is taking active part with the health sector in Two submissionx of water mission i.e.Eradication of Guinea worm and control of flurosis.

- The rural water and sanitation programme implemented by public health engineering department is also

- Corporations and Municipal authorities are also co-ordinating with health sector for ensuring safe drinking water supply to the population concerned.

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- Inspite of the tangible progress made in the Health situation of the country over the last few decades, it is observed that the progress achieved in many important areas does not commensurate with the efforts and resources that are being spent. One of the reasons always points to lack of " AWARENESS " in the community about the health matters. Hence, the mass media activities under family welfare programme and also the information, education and communication activities under India Population project are being concentrated on the following areas for creating awareness in the population.

1. Marriage for girls only after 18 years and for boys only after 21 years.

2. Early registration and frequent examination of pregnant wo-men.

3. Prevention of anemia by Iron and folic acid tablets.

4. Prevention of tetanus by two injections of Tetanus Toxoid.

5. Breast feeding.

6. Immunisation of child against 6 killer diseases.

7. Smally family norm.

8. Oral re-hydration solution for diarrhoea.

9. Preventive aspects of communicable diseases lime malaria, tuberculosis and leprosy.

10. Blindness control.
11. Health nutrition.
12. Personal Hyg. iene
13. Enviironmental sanitation
14. Mental health
15. Dangers of un-healthy life styles, such as overeating, smoking, drinking, alcohol and drug abuse.

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- An area covering a population between 10,000-25,000 is called as Mandal Panchayat. There will be one elected member for every 500 population in the Mandal Panchayat area. The Zilla Parishads are formed by these Mandal Panchayats and Taluk Panchayat samithies.

In the Zilla Parishad system of Karnataka State the planning process and the Management of Health Institutions is being entirely looked after by the Zilla Parishads. The local problems and priorities are being given priority in the planning, organisation and operational aspects of primary health care.

PART B PRIM ARY HEALTH CARE AND HEALTH CARE SYSTEM:

(1) Has Primary health care approach been applied to all levels of the State's health system or just to the services in rural areas ? (provide details).

Prim-ary Health Care approach has been applied to all levels of the State health system, both in rural areas as well as in urban areas.

In the rural areas the institutions involved are sub-centres, primary health centres, community health centres and also maternity hospitals.

In the urban areas, the primary health care services concept has been well appreciated and carried out through district hospitals and also specialised hospitals like tuberculosis hospitals, leprosy hospitals, mental health and Cancer Institutions.

Integrated approach consisting of preventive, promotive, durative, laboratory and rehabilitative services are being rendered in district and major hospitals also.

(2) Has the health pyramid been established? Indicate the extent to which it is functional.

The health pyramid has its base the community. There are 15460 community health workers on roll, 7793 sub centres and 836 primary health centres have been made functional. In addition 306 additional Primary Health Centres will be established wherein the Karnataka State will be achieving 100% of the PHCs required for the State by the end of VIith five year plan. There are more than 1140 general

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duty medical officers 1042 health assistants(female), 943 health assistants (male), 8059 female health workers, 5163 health workers (male)and 381 Block health educators providing supervision ,technical support and guidance.

156 Community Health Centres with more than 420 specialists are functioning at these centres providing referral support to primary health centres.

There are 13 district hospitals, 7 major hospitals, 7 specialised hospitals and 3 epidemic disease hospitals at the apex of the pyramid giving full technical support.

(3) Has the State health care system been orinted mainly to provide support to the peripheral services and to complement their ac-tion by means of easy and timely channels of referral cases or problems beyond their competence? Please explain with examples?

The referral system is a week-link of primary health care in Karnataka State. There is no well streamlined established referral services.

(4) Has the health care system been built up in the light of available national resources so that it can evolve in a sustainable manner based on the principles of self reliance and self determination? Has there been any serious attempt to renew and strengthen strategies for health for all?

No innovative efforts have been made to renew and strengthen the strategies for health for all especially to build up a health care system based on the principles of self reliance and self determinations.

(5) Does sufficient flexibility exist to allow the health care system to adapt itself to local problems, natural conditions and available resources as well as changing situations? (Please provide details)

With the incoming of Zilla Parishad system, the flexibility have been positively possible to adopt to local problems, natural conditions and available resources as well as changing situations. Some of the examples are:

(i) Control of local endemic diseases like Kysananur Forest disease, Japanese enc-ephalitis with the Zilla Parishad efforts only.

(ii) Drought relief measures

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(iii) Commissioning of hospital pharmacies to improve the availability of IV funds.

(iv) Gearing up the construction works of primary health centre buildings.

(v) Purchase of drugs, to all the peripheral institutions.

(vi) Purchase of essential equipments and vehicles.

(6) Has democratic decentrailisation with formation of Zilla Parishad, Panchayat Samiti and Panchayats & devolution of powers and allocation ofr resources been established and implemented? In other words, what steps have been taken to intensify social and political action for health for all?

The Mandal Pradhans while participating in the Zilla Parishad discussions will appraise various health problems and bring notice of the felt need proposals. There will be different committes set up under the Zilla Parishads which scrutinises these proposals, and proposals are formulated through the people at grass roots. We can conclude that there is full social and political action for health for all in divising their own health plans based on health needs.

(7) To what extent is primary health care being implemented in co-operation with other sectors. Indicate the co-ordination mechanisms operational in the state for linking health with other sectors.

The co-ordination mechanism operational in the State for implementation of health programmes is being ensured through two important review meetings.

(1) Monthly multilevel review reports (MMR)
(2) 20 Point Programme (KDP)- Review.

In these two review meetings different sectors are involved, take stock of the progress, realise the problems and bottle-necks and also finds solution to gear up the problems.

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(8) To provide support for PHC are programmes under the responsibility of health care system being properly co-ordinated at the Central level? Nearer the periphery co-ordination should turn into integration. At the community level all programmes should be integrated as part of the community's programme of socio-economic development. Has, intersectoral collaboration been made a force for achieving health for all? What steps have been taken to develop and mobilize leadership for health for all?

Since the same type of review meetings also takes place not only at the state level but also at District/ Taluk and block level, the co-ordination mechanism automatically is resulting in integration of different schemes in the implementation of the programme. However the leadership for health for all is not being well ensured.

(9) Has priority been given to understand areas and high risk groups in the population? While the emphasis is on total coverage, the support of the progressively more sophisticated higher levels of the health system ensures that health care of highest quality is made available and accessible to all when needed.

Looking at the health situation of different areas and progress under different health programmes over the years, it is easy to understand which are the backward areas, resistant areas and high risk areas. Action is being taken to allocate more resources for such areas even from the planning stage and the health system is being geared to bring a balance between the ' HAVES ' and ' HAVE NOTS '.

(10) Has management information system in support of health care been started? Is it functional and to what extent (with respect to state coverage)?

Management information system as a support of health care has been initiated. Computer has been started functioning. Soft ware have been developed. Work is under progress. Although the whole state is covered in MIES the reports and compilation is not giving complete picture of the information as a whole.

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(11) What are the major constraints(Other than financial) faced by the State in implementation of primary health care programme?

The major constraints faced by the State in implementation of the primary health care programme are as follows:-

(1)Referral system is a weak-link
(2)Health care system not developed on the principles* *
(3) Lack of leadership for health for all.
(4)Appropriate technology not well devised.
(5)Health services research yet to be initiated.
* of self-reliance and self determination.

(12) What suggestions do you have towards removal of these constraints?

A separate nodal cell to implement different components of primary health care is necessary to ensure better co-ordination between the health care system, health schemes and supporting activities both within the sector as well as the other sectors.

PART C : PEOPLE 'S INVOLVEMENT IN AND MANAGEMENT OF HEALTH CARE

(1) Has State Government developed long term strategies through ?

(i) Un-equivocal committment to primary health by political leaders at every level.

- Based on the philosophy of equitable distribution of health resources under primary health care, the establishment of 3 tier health system i.e, sub centres, primary health centres and community health centres has been well understood by all the political parties, community participation through the Zilla Parishads is being guaranteed to improve the progress and quality of health care services.

(ii) Acceptance of the principle that health is an over-riding social goal.

- The ' medical cure ' aspect of health system has been accepted as priority than the 'health care ' . Still the community has to realise health to be the social goal and thus it is still left to the health sector only.

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(iii) Supporting industrial, social, political and production related organisations in the pursuit of this goal.

- Not yet felt.

(2) The role of people's (not government)organisation in :

(i) initiating large scale promotional and preventive action locally.

- Immunisation camps, family welfare cam-ps, health check-up camps, blood donation camps and eye surgery camps.

(ii) ways and means adopted for developing effective methods informing the public about the health matters.

- M.E.M. activities under family welfare programmes, information, education, communication activities through India Population project are being well supported by the people involvement and also through various health education messages.

(iii) facilitating intra-sectoral co-ordination at all levels.

- yet to come into existence at all levels.

(iv) investing time and effort in strengthening the local capacity to manage organisations for socio-economic development.

- the role of people in managing the organisations has yet to be utilised.

(v) monitoring the health care system to ensure that it does not divorce itself from its committment to the implementation of the primary health care approach.

- people are not involved in monitoring the health care system so far.

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PART D: HEALTH MAN-POWER DEVELOPMENT:

(1) Has priority been given to developing health manpower required to provide health care to all people at all levels, with particular reference to rural sector?

The area of health man-power development has been very good in the State. The State has developed sufficient institutions to train various categories of health man-power. Some examples are: Medical Colleges (18), Health & Family Welfare Training Centres (5), ANM Training Centres (19), L.H.V.Training Centres (6), Health Inspector's Training Centres (7), Training Centres for refractionists (4). Training for x-ray technicians (10), Particularly, regarding the availability of man-power, there is no scarcity even of the specialist cadres.

(2) What steps have been taken to strengthen district health system based on PHC/decentralisation approach?

The bringing in of democratic decentralisation of developmental activities through Zilla Parishads, the local self-government in the districts and down below has given birth to the district health system from 1.4.1987. The district health system is being guided and supported by the health committees of the Zilla Parishads. Some of the features of the district health system are enumerated as under:-

(a) The funds are still flowing from the State Government to Zilla Parishads and then to the District health system for development and maintenance. They have to mobilise their own resources in future.

(b) With certain limitations the administration and financial matters have been vested with the Zilla Parishads.

(c) The State level Directorate continues to be responsible for conveying ' technical knowhow '.

(d) The mangement of health institutions the release of funds, the supply and logistics are the prime responsibilities of Zilla Parishads.

(e) The most important ' planning process ' has also been made the responsibility of district health system.

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(f) The Zilla Parishads are responsible for formulating the proposals regarding the developmental schemes.

(3) What steps have been taken to orient education and training programmes for health personnel, emphasizing relevance to health services requirements, by providing learning experiences in functioning health systems based on primary health care?

The primary health care topic has been included in all types of training programmes. The trainees are being told especially the infrastructure establishment under rural health, the eight essential elements of primary health care and also the 8 supporting activities under ppimary health care. Further, the essential principles of primary health care like equitable distribution, community participation, multisectoral action and choice of appropriate technology are being emphasised in the training sessions with relevant practical situations and examples.

(4) Are the community health workers/periphery level workers sufficiently remunerated/regularly paid and are they integrated with socio and economic life of the community?

The technical staff employed under health sector is on permanent basis with full security of job, salaries and allowances and other pensionary benefits. Since these health workers are regular employees of State Government, perhaps, they will be able to involve in social aspects of the community but very less in economic aspects of the people.

(5) Are the peripheral health staff trained to deal with local problems? Is training imparted close to the working environment? Does the training have components of appropriate technology?

The Health Workers have been trained to deal with local health problems and the training is being imparted close to the working environment but there has not been much improvement in the area of appropriate technology.

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(6) Does the initial training of supervisors including Medical Officers emphasize on the managerial aspects of health care which is further developed throughout the whole process of continuing education?

Realising that the infra-structure facilities are adequate and management is lacking, short term training courses are being arranged by the Directorate of Health Services for different categories of staff like Medical Officers, health workers, health assistants and health educators. Further, the India Population Project -III(K) is continuously arranging management development training programme since its inception and so far more than 500 Medical Officers and other para-medical people have been trained to improve the managerial knowledge and skills.

(7) Does training of peripheral workers/community health workers include the kinds of activity that will meet the expressed needs of the community? Is training imparted in stages after the knowledge and skills imparted at the earlier training have been successfully used and implemented?

The community feels that training and carrying out the activities concerned with ' Health cure ' is more important and beneficial than ' Health care '. Hence, the training of health workers perhaps may not be meeting the expressed needs of the community.

(8) Do continuing training programmes have the following components?

Continuing Education:
(a) Upgrading the knowledge and skills of Health workers.

- The inservice candidates are being frequently exposed to continuing education programmes to update the knowledge and skills in health care delivery services.

(b) Maximum use of existing health facilities.

- The inservice trainees are being taken to various health institutions during the training programmes and short lecture session are being given on the spot to

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demonstrate as a model for delivering the services including field units. These lecture sessions will be able to impart upto date and scientific information to the inservice candidates.

(c) Revision and upgradation of the contents.

- As and when new problems and new situations are met the contents in the training programme are being revised and updated to meet the requirements.

(9) Is there a specific programme for training the trainers which has provision for using modern teaching/learning methods and social orientation?

Medical and para-medical personnel working in training centres, Officers of the Directorate are being deputed to Central Training Institute, Gandhigram, National Institute of Health and Family Welfare, National Institute of Communicable Diseases New Delhi and National Institute of Nutrition, Hyderabad to train the key trainers.

(10) In your view what are the major lacunae and problems related to man-power development in your State ?

As far as, Manpower development is concerned, there is no problem in the State, since there are sufficient and concerned training institutions for various categories of technical staff including specialists..

(11) Can you suggest how these lacunae can be overcome?

Does not arise.

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PART E FINANCING HEALTH CARE:
Please provide the following details for 1987-88 for health budget.

(Rs.in lakhs)

		Non-Plan	Plan
(1)	Budget allocation	6975.25	2047.05
(2)	Budget received	6975.25	2047.05
(3)	Additional inputs made by State Government.	-	-
(4)	Expenditure under 'Health'	6666.455	
(5)	Expenditure in Rural Health Care	3601.642 *	
(6)	Expenditure in Urban Health Care.	3064.813 *	
(7)	Per capita expenditure - ' Rural '	Rs.9.92 per capita	
(8)	Per capita expenditure- ' Urban '	Rs.20.56 per capita	

(9) In your view what should be optimal (but realistic) level of funding for:

	Present	Proposed	
(a) Urban health care	66.5%	33.5%	50.00%
		OR	
(b) Rural health care	33.5%	66.5%	50.00%

* (excluding expenditure under building works)

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LEVEL OF ACHIEVEMENT OF SOME NORMS
(Position as on 31.12.89)

STATE: KARNATAKA

Sl. No.	Parameters/Indicaters	National norms	Level of achievement
1	2	3	4
1.	Trained Dai	Atleast one for each village.	More than one per village.
2.	Trained village health guide	One for each village/1000 population.	One for each 1955 population
3.	Population served by health workers (male and female)	M: 3000-5000 F: 3000-5000	1 : 5119 1 : 3356
4.	Ratio of HA(M):HW(M)	1 : 6	1 : 6
5.	Ratio of HA(F):HW(F)	1 : 6	1 : 7.5
6.	Population covered by a sub-centre.	3000-5000	3935
7.	Population covered by a PHC	20,000-30,000	36,678
8.	Population covered by a Community Health Centre	About 1 lakh	2,19021
9.	No.of sub-centres for each PHC.	6 sub centres	9
10.	No.of Primary Health Centres for each Community Health Centre.	4 PHCs	6

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PROGRESS OF PRIMARY HEALTH CARE IN THE STATE OF KARNATAKA

	Targets between 1979-90
(1) DAIS TRAINING PROGRAMME	
(i) Total *no.of dais required by 31.3.1990	49250
(ii) Total no.of dais trained as on 30.6.1988	31587
(2) VILLAGE HEALTH GUIDE PROGRAMME	
(i) Total no.of VHG required	31239
(ii) Total number of VHG trained as on 30.6.88	15128
(3) ESTABLISHMENT OF SUB CENTRES:	
(i) Total no.required by 31.3.1990	7025
(ii) Total no.functioning as on 30.6.88	7677
(iii) Total no.required in tribal/ backward areas as on 31.3.1990	1945
(iv) Total no.functioning in tribal/ backward areas as on 30.6.88	1771
(4) ESTABLISHMENT OF PRIMARY HEALTH CENTRES(PHC)	
(i) Total no.required by 31.3.1990	1139
(ii) Total no.functioning as on 30.6.88	545
(iii) Total no.required in tribal/backward areas as on 31.3.1990	294
(iv) Total no.functioning in tribal/ backward areas as on 30.6.88	124
(5) ESTABLISHMENT OF COMMUNITY HEALTH CENTRES (CHCS)	
(i) Total number required by 31.3.1990	156(50% of 313)
(ii) Total number functioning as on 30.6.88	119
(6) Man-power Status (Format enclosed)	

*(no.-number)

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STATE: KARNATAKA

STAFFING POSITION
(As on 31.12.1989)

Sl. No;	Category	Total no. required by 1990	No. sanctioned	No.in position	No.of vacant posts.
1	2	3	4	5	6
	Specialists (Sl.1 to 4)				
1)	Surgeons				
2)	Obst. & Gynaes				
3)	Physicians		3630	3305	325
4)	Paediatricians				
5)	Medical Officer				
6)	Community Health Officer		-	-	-
7)	Pharmacist		2337	2192	145
8)	Lab.Technician		1303	1119	184
9)	Radiographer		50	27	23
10)	A.N.M. /HW (Female)		9137	8995	142
11)	Health worker (male)		5556	5083	473
12)	Health Assistant (Female)		1226	1129	97
13)	Health Assistant (Male)		950	901	49
14)	Nurse Midwife		-	-	-
15)	Health Educator		415	376	39

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(1)	(2)	(3)	(4)	(
	DPT (children below 3 yrs)	85	68.0	(Upto Dec
	Polio (infants)	70	67.4	-do-
	BCG (infants)	80	83.1	-do-
	DT (new school entrants 5-6 yrs)	85	48.0	Upto Nov
	Typhoid (new school entrants 5-6 yrs)	85	Vaccination withd from the progra	
15.	Leprosy- percentage of disease arrested cases out of those detected.	60	66.40 (Upto end Nov.1989	
16.	TB percentage of disease arrested cases out of those detected.	75	N.A	
17.	Blindness - Incidence of (%)	0.7	N.A	